Junge Family CHIROPRACTIC, LLC

Name: _____Date: _____

Address: _____City: _____State: _____ Zip: _____

Email: _____Occupation: _____

Phone: _____Cell: _____Work Phone:_____

DOB:_____ Age:_____ Married Single Divorced Widowed Kids: _____

Referred By/How did you hear about us:_____

YOUR CHILDHOOD YEARS (TO AGE 17)

	YES	NO
Did you have any childhood illnesses?	☐	☐
Did you take medications? (antibiotics, inhaler etc)?	☐	☐
Did you have surgery?	☐	☐
Were you vaccinated?	☐	☐

	YES	NO
Have you fallen / jumped Fall from a height over three feet?	☐	☐
Any car accidents as a child?	☐	☐
Did you suffer any other traumas (physical or emotional)	☐	☐
As a child, were you under regular chiropractic care?	☐	☐

Please share any additional information:

_____

_____

ADULT - (18 TO PRESENT)

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐

	YES	NO
Have you been in any accidents?	☐	☐
Do/did you play adult sports?	☐	☐

Surgeries

Type_____When_____

Type_____When_____

Medications

Type_____For_____How Long_____

Type_____For_____How Long_____

Type_____For_____How Long_____

Any side effects or complications _____

Do you try to avoid taking medications? ☐ YES ☐ NO

Would you like to decrease the amount of medication you are currently on? ☐ YES ☐ NO ☐ N/A

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no symptoms or complaints, and are here for wellness services, please check here: _____

Otherwise please briefly explain what brought you to our office today:

_____

_____

This interferes with: ___Work ___Sleep ___Walking ___Hobbies ____Family ___Leisure ___Other

How does it interfere: _____

Additional concerns: _____

Have you seen anyone else for this issue? ____yes _____no If yes, who? _____

What was the result_____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

□ Neck pain/stiffness	□ Mid back pain/stiffness	□ Low Back pain/stiffness	□ Numbness
□ Headaches	□ Difficulty breathing	□ Pins and needles in legs	□ General tension
□ Pins and needles in arms	□ Asthma	□ Muscle Spasms	□ Irritability
□ Dizziness	□ Allergies	□ Constipation	□ Mood Swings
□ Ringing in ears	□ Heartburn	□ Diarrhea	□ Sleeping problems
□ Mental fog	□ Digestive trouble	□ Urinary Problem	□ Fatigue
□ Sinusitis	□ Skin problems	□ Menstrual Irregularity	□ Extremity pain
□ Seizures	□ Change in weight	□ Menstrual Pain	□ TMJ problems

Other(s)_____

LIFESTYLE QUESTIONS

	YES	NO		YES	NO
Do you eat a healthy diet?	☐	☐	Belong to a health club?	☐	☐
Do you get quality sleep?	☐	☐	Watch 5 hours of TV per week?	☐	☐
Do you get adequate exercise?	☐	☐	Use computer 2 hours a day?	☐	☐
Do you drink enough water?	☐	☐	Sit more than 10 hours a day?	☐	☐
Use vitamins?	☐	☐	Do you try to improve your health?	☐	☐

Rank your emotional health? ☐Poor ☐ Fair ☐ Good ☐ Excellent

Rank your occupational health? ☐Poor ☐ Fair ☐ Good ☐ Excellent

Rank your overall health? ☐Poor ☐ Fair ☐ Good ☐ Excellent

I consent to a complete chiropractic examination and to any radiographic examination the doctor deems necessary.

Signature _____

JUNGE FAMILY CHIROPRACTIC

4164 18th Ave, NW Rochester, MN 55901
(507) 208-4481 www.JungeFamilyChiropractic.com